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	50G050	A. BUILDING _____ B. WING _____	R-C 01/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT A	RYAN ROAD BUCKLEY, WA 98321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS This report is the result of a Focused Fundamental Survey, requested by CMS, at Rainier School PAT A. The survey occurred on 01/07/19, 01/08/19, 01/09/19, 01/10/19, 01/11/19, 01/14/19, and 01/15/19. The Survey was extended into the Condition of Active Treatment. Failed provider practice was identified. The survey was conducted by: Gerald Heilinger Jim Tarr Patrice Perry Linda Davis Olivia St. Claire Arika Brasier Linda Harris, CMS Nurse Surveyor was onsite from 01/07/19 - 01/11/19. The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, ICF/IID Survey and Certification Program PO Box 45600, MS: 45600 Olympia, WA 98504 Telephone: 360-725-3215	{W 000}		
{W 102}	GOVERNING BODY AND MANAGEMENT CFR(s): 483.410 The facility must ensure that specific governing body and management requirements are met.	{W 102}		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 102}	Continued From page 1 This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure its systems and oversight kept all Clients safe, and there were systems in place to ensure all staff provided aggressive active treatment. This failure put Clients at risk of injury and prevented them from receiving the training they needed to increase their independence. This is a repeat citation from the 06/29/18 survey. Findings included . . . Through record reviews and interviews, it was determined the facility's incident management system did not ensure investigations were thorough and did not ensure the safety of Clients during investigations. The facility was utilizing a discharge planning process that did not ensure that Clients designated for discharge were in fact in need of discharge. The facility did not have a system in place to ensure safety of Clients when out in the community. See W104 for details. Through observations, record reviews, and interviews, it was determined the facility did not ensure that all staff provided aggressive active treatment services. See W159 and W195 for details.	{W 102}		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility.	W 104		

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This STANDARD is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility's governing body failed to ensure it had an incident management system that ensured protection of all Clients, managed all aspects of off-campus trips in a way which met all Clients' needs and ensured their safety, and ensured their system for considering Clients for discharge was functioning correctly. This failure put Clients at risk of harm and potentially placed Clients out of the facility when they were in need of active treatment services.

This is a repeat citation from the 05/31/17 survey.

Findings included ...

A. Incident Management System

Thorough Investigations-

Review of ten incident investigations showed five did not have a thorough investigation when the facility did not look into all aspects of the incident that prevented the facility from developing a plan of correction that would prevent future incidents from happening:

1. Review of facility Incident Report #8374 showed a Client put a piece of laminated paper in his mouth and showed signs of choking. The investigation did not look into whether the Client was in a structured activity at the time, how many staff were in the area and what they were doing,

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or if there were other items that could have been ingested.

2. Review of facility Incident Report #8423 showed a Client ate a piece of an Attends (adult protective garment) while being assisted in the bathroom by staff. The facility investigation did not look into whether there were specific directions for staff to follow related to Attends and using the bathroom, and what staff should do to prevent additional incidents from happening.

3. Review of facility Incident Report #8432 showed 16 Clients were given a shingles vaccine that required a nurse to mix a dry powder with a liquid adjuvant suspension and inject the resulting combination into the Clients. The facility received a vial of the powder and a vial of the adjuvant solution for each Client. The Nurse administered the liquid adjuvant suspension to the Clients without mixing the powder into it. The facility investigation did not indicate that all nurses were trained on the process for the shingles vaccine prior to administration, did not indicate there was a review of the instructions provided with the medication to determine if they were clear, and did not provide a review of the Nurse's prior history of medication errors.

4. Review of facility Incident Report #8416 showed a Client fell in his bedroom and incurred a cut above the eye and bleeding from the nose. The fall was not witnessed. The facility investigation did not look into potential causes of the fall such as a medical condition or clutter in the room. The staff who found him stated that he probably tripped over shoelaces, but there was no investigation of this possible cause for the fall. It

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appeared this explanation was taken at face value. Other parts of the investigation indicated he was to wear a helmet for protection from falls, but the investigation did not look into whether he was wearing one at the time of the fall.

5. Review of facility Incident Report #8342 showed a Client fell. The facility investigation did not look into potential causes of the fall.

During an interview on 01/09/19 at 4:40 PM, Staff A, Superintendent, Staff P, Developmental Disabilities Administrator (DDA) 2, and Staff S, Incident Management Coordinator, stated that the above-mentioned investigations did not contain the mentioned elements.

Protection Plan -

Review of ten incident investigations showed that one did not ensure there was a protection plan in place during the investigation for Client safety and to prevent further incidents:

Review of facility Incident Report #8440 showed a facility Nurse discovered a medication in a Client's medication drawer that should have been given the night before. The facility determined which nurse should have given the medication but put no protection plan in place for seven days following the discovery of the error.

During an interview on 01/09/19 at 4:40 PM, Staff A, Superintendent, Staff P, DDA2, and Staff S, Incident Management Coordinator, stated that the protection plan was not put in place for 7 days

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after the investigation and that the nurse had proceeded with regular duties during that time.

Investigations not completed within five days:
Review of ten incident investigations showed that one was not completed within the required five days:

Review of facility Incident Report #8406 showed a Client did not receive the first dose of a colonoscopy preparation. The facility did not finish their investigation until nine days later.

During an interview on 01/09/19 at 4:40 PM, Staff A, Superintendent, Staff P, DDA2, and Staff S, Incident Management Coordinator, stated that the facility did not complete their investigation within the required five days as stated in the regulation.

B. Off-campus Trips

Trip Destination Change-

Observation on 01/07/19 at 10:05 AM outside 2010A and 2010B Houses showed that Client #4, another Client from 2010A, and one Client from 2010B were loaded into a lift van for a trip into the community for lunch.

During an interview on 01/08/19 at 2:30 PM, Staff W, Attendant Counselor Manager (ACM), stated that the destination of the trip on 01/07/19 had changed due to a closure of the original destination.

Record review of Standard Operating Procedure (SOP) titled, "3.17 Off-Campus Leisure Trips,"

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dated 12/13/18, showed that staff were not required to call the Duty Office for a venue change during a trip if the new destination was within a five-mile radius. It did not show what/where the center point of the five-mile radius was.

During an interview on 01/14/19 at 11:00 AM, Staff P, DDA2, stated that the Duty Office monitored the changes made to destinations to ensure the staff made appropriate choices for new destinations when they received the original off-campus form at the end of the trip.

During an interview on 01/14/19 at 11:10 AM, Staff H, Assistant Superintendent, and Staff I, Quality Assurance (QA) Director, were asked how the facility ensured venues chosen for off-campus trips were meaningful for Clients when the staff were allowed to change the venue during a trip without informing or getting approval from the facility management. They stated that the QA Department did random sampling of trips to ensure appropriateness of destination changes. They did not think staff would make poor choices for any venue change, although they allowed it was possible. They acknowledged there was no mechanism within the new policy for the facility to approve changes for all trips at the time the change occurred.

Lack of trip drivers-

During an interview on 01/08/19 at 8:50 AM, Staff C, ACM, stated that staff cancelled the trip planned for that day for Client #4 and other Clients due to no available driver.

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During an interview on 01/08/19 at 10:47 AM, Staff C stated that her driver did not come in to work that day. She had arranged with the Adult Training Program (ATP) to provide a driver in case the house driver was not at work, however ATP informed her they could not provide a driver as they were short staffed. Staff C stated that there were not many drivers as some staff were uncomfortable driving.

Record review of the Position Description Form (PDF), revised 02/2018, for Attendant Counselors (ACs) showed that within their scope of work they would be required to perform duties both on and off campus that included transport/escort of Clients to and from activities and appointments per their Individual Habilitation Plans (IHPs) and their needs. Staff were expected to be willing and able to transport Clients as necessary; maintain competency in all aspects of the requirements; hold a valid driver's license in order to operate a vehicle both on and off campus; and drive Clients to and from appointments and activities.

During an interview on 01/14/19 at 11:00 AM, Staff P, DDA2, stated that there was nothing he could show to this surveyor that indicated staff were able to opt out of the requirement to drive Clients into the community. He stated that some staff were uncomfortable driving the vans.

C. Discharge Planning Process

During an interview on 01/10/19 at 11:30 AM, Staff L, Psychology Associate, stated that Client #5 was scheduled to move to a nursing facility.

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Record review of a Planned Action Notice (PAN) from DDA, dated 12/13/18, addressed to Client #5, showed, "Based on individualized assessment, you are not in need of or able to benefit from continuous and aggressive active treatment services ("active treatment")." The PAN showed Client #5's Intermediate Care Facility (ICF) benefit terminated on 01/14/19.

During an interview on 01/11/19 at approximately 10:30 AM, Staff II, Project Manager, stated that the facility had developed a discharge planning process which involved an initial review by the Interdisciplinary Team (IDT) to see if the Client might qualify for services in a nursing home. If that review was positive for qualifying for services in a nursing home, Staff II arranged for an independent assessment of the Client by a staff not associated with the facility. If there was disagreement between the two separate assessments, a third assessment was conducted by the Developmental Disability Administration (DDA) Clinical Director. Staff II stated that if the IDT assessment and the second assessment were positive for receiving services, or if the Clinical Director assessment and one of the other two assessments were positive for receiving services in a nursing home, the Client's name was sent to the DDA Central Office for placement on a list and the process for initiating a discharge was started.

Record review of the IDT assessment to determine if Client #5 was appropriate for a nursing home showed it was dated 08/01/18 and that he met criteria for placement in a nursing home. Review of the second assessment, no date provided, showed there was no conclusion on the document. Staff II noted on the IDT

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W 104	Continued From page 9 assessment it was inconclusive for Client #5 continuing to benefit from ICF/IID (Individuals with Intellectual Disabilities) services. Record review of the assessment completed by the DDA Clinical Director on 10/31/18 for Client #5's showed several recommendations for the IDT to pursue related to assessing and treating Client #5, and included the following statement, "The Interdisciplinary Team needs to determine if an alternative placement is in Mr. [Client #5's last name] best interests and develop a discharge plan." During an interview on 01/11/19 at 8:22 AM, Staff II stated that Client #5's evaluation for potential placement at another facility was inconclusive. During an interview on 01/10/19 at 3:32 PM, Staff HH, Placement Coordinator, stated that the facility was pursuing discharge from the facility for Client #5. During an interview on 01/11/19 at 11:45 AM Staff II stated that Client #5 was confirmed for discharge in error. She stated that she did not know why Client #5 was identified by the DDA Central Office as in need of discharge planning. Review of a draft copy of the facility SOP titled, "3.19 Admission, Discharge, & Internal Client Movement," showed the proposed facility policy did not include the procedure the facility used for current discharge planning related to Clients' not benefitting from Active Treatment.	W 104		
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1)	W 111		

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W 111	Continued From page 10 The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of six Sample Clients (Client #6) had accurate health information when another Client's dental information was placed in Client #6's medical file. This failure resulted in staff not having access to the correct and current information regarding Client #6's dental needs. Findings included ... Record review of Client #6's medical file at Klamath House showed a Dental Assessment, dated 11/14/18, for a different Client who resided at the home. During an interview on 01/08/19 at 9:48 AM, Staff Q, Attendant Counselor Manager, stated the wrong Client's Dental Assessment was filed in Client #6's medical book.	W 111		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure five of ten incidents were thoroughly investigated. This failure prevented the facility from knowing all aspects of the incidents in	W 154		

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order to develop an effective prevention plan.

This is a repeat citation from the 05/31/17 survey.

Findings included. . .

1. Review of facility Incident Report #8374 showed a Client put a piece of laminated paper in his mouth and showed signs of choking. Examples of things the facility did not look into included: whether the Client was in a structured activity at the time; how many staff were in the area; what the staff were doing; or if there were other items that were ingestible.

During an interview on 01/09/19 at 4:40 PM, Staff A, Superintendent, Staff P, Developmental Disabilities Administrator (DDA) 2, and Staff S, Incident Management Coordinator, stated that the investigation did not contain the above-mentioned elements.

2. Review of facility Incident Report #8423 showed a Client ate a piece of an Attends (adult protective garment) while being assisted in the bathroom by staff. Examples of things the facility did not look into included: if there were specific directions for staff to follow related to Attends and using the bathroom, and what staff should do to prevent additional incidents from happening.

During an interview on 01/09/19 at 4:40 PM, Staff A, Superintendent, Staff P, DDA2, and Staff S, Incident Management Coordinator, stated that the investigation did not contain the above-mentioned elements.

3. Review of facility Incident Report #8432 showed 16 Clients were to be given a shingles

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vaccine which required the nurse to mix a dry powder with a liquid adjuvant suspension and give the resulting combination to the Clients. The facility was provided a vial of the powder and a vial of the adjuvant solution for each Client. The nurse administered the adjuvant solution to the Clients without mixing the powder into it. Examples of things the facility did not look into included: if all nurses were trained on the process for the shingles vaccine prior to administration, if there was a review of the instructions provided with the medication to determine if they were clear, and a review of the Nurse's prior history of medication errors.

During an interview on 01/09/19 at 4:40 PM, Staff A, Superintendent, Staff P, DDA2, and Staff S, Incident Management Coordinator, stated that the investigation did not contain the above-mentioned elements.

4. Review of facility Incident Report #8416 showed a Client fell in his bedroom and incurred a cut above the eye and bleeding from the nose. The fall was not witnessed. The facility investigation did not look into potential causes of the fall such as a medical condition or clutter in the room. The staff who found him stated that he probably tripped over shoelaces, but there was no investigation of this possible cause for the fall. It appeared this explanation was taken at face value. Other parts of the investigation indicated he was to wear a helmet for protection from falls, but the investigation did not look into whether he was wearing one at the time of the fall.

During an interview on 01/09/19 at 4:40 PM, Staff A, Superintendent, Staff P, DDA2, and Staff S, Incident Management Coordinator, stated that the

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W 154	Continued From page 13 investigation did not contain the above-mentioned elements. 5. Review of facility Incident Report #8342 showed a Client fell. The facility investigation did not look into potential causes of the fall. During an interview on 01/09/19 at 4:40 PM, Staff A, Superintendent, Staff P, DDA2, and Staff S, Incident Management Coordinator, stated that the investigation did not contain the above-mentioned elements.	W 154		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of ten incidents included a protection plan while the incident was being investigated. This failure put Clients at risk of potential harm. Findings included. . . Review of facility Incident Report #8440 showed a facility nurse discovered a medication in a Client's medication drawer that should have been given the night before. The facility determined which nurse should have given the medication, but put no protection plan in place for seven days following the discovery of the error. During an interview on 01/09/19 at 4:40 PM, Staff A, Superintendent, Staff P, Developmental	W 155		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 155	Continued From page 14 Disabilities Administrator 2, and Staff S, Incident Management Coordinator, stated that the protection plan was not put in place for seven days after the investigation began, and the nurse had proceeded with regular duties during that time.	W 155		
W 156	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of ten incidents had the investigation completed within the required five-day timeframe. This failure prevented the facility from knowing what happened in a timely manner and ensuring any needed changes were made to prevent further incidents. Findings included. . . Review of facility Incident Report #8406 showed a Client did not receive the first dose of a colonoscopy preparation. The facility did not finish their investigation until nine days later. During an interview on 01/09/19 at 4:40 PM, Staff A, Superintendent, Staff P, Developmental Disabilities Administrator 2, and Staff S, Incident Management Coordinator, stated that the facility did not complete their investigation within the required five days as stated in the regulation.	W 156		
{W 158}	FACILITY STAFFING	{W 158}		

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{W 158}	Continued From page 15 CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: This regulation was not reviewed as part of the Focused Fundamental Survey for 01/15/19. It remains out of compliance from the 05/31/17 Survey and the 06/29/18 Survey.	{W 158}		
{W 159}	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the Qualified Intellectual Disability Professionals (QIDPs) provided aggressive oversight of all aspects of the Clients' living experience at the facility for six of six Sample Clients (Clients #1, #2, #3, #4, #5 and #6) and one Expanded Sample Client (Client #7). This failure prevented Clients from gaining greater independence or moving to a less restrictive environment. This is a repeat citation from the 05/31/17 Recertification Survey and the 06/29/18 Post Survey. Findings included...	{W 159}		

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{W 159}	Continued From page 16 Adult Training Observation at Program Area Team (PAT) A Headquarters, Room 1E, on 01/09/19 at 10:07 AM showed Staff GG, Adult Training Specialist (ATS), physically placed and held a wooden block in Client #1's hand. Staff GG then physically moved Client #1's hand to place a rectangular shaped block on a peg. Client #1 looked away from the activity as it occurred. Review of Client #1's program #2008.1 showed, "[Client #1's first name] will place the square block onto the square peg with full physical assistance for 8 out of 10 data sessions." Client #1 progressed to the second step of the program, #2008.2, on 12/26/18. The new objective showed, "[Client #1's first name] will place a rectangular block onto the rectangular peg with full physical assistance for 8 out of 10 data sessions." During an interview on 01/09/19 at 11:00 AM, Staff GG, ATS, stated that the purpose of the program was to engage Client #1 in activity. He stated that Client #1 progressed from the first step and was now learning a new skill. When asked what skill Client #1 learned when staff physically placed and held a block in his hand, he stated, "Participation in an activity." During an interview on 01/10/19 at 10:03 AM, Staff AA, QIDP, stated that she was not aware of what Adult Training taught Client #1. She stated that she did not observe Client #1 in his Adult Training environment due to having too many assignments. Staff AA also stated that she had read and signed off on the training plan for the Adult Training class that Client #1 attended.	{W 159}		

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{W 159}	Continued From page 17	{W 159}		

Learned helplessness

Record review of Client #1's Individual Habilitation Plan (IHP), dated 07/12/18, showed he had developed learned helplessness and depended on staff to initiate and complete his bathing, grooming, and dressing.

During an interview on 01/10/19 at 10:03 AM, Staff AA, QIDP, stated that Client #1's IHP had no staff instructions to address his learned helplessness.

QIDP failed to evaluate success/lack of progress in program teaching plans

1. Record review of program #B 2.2 for November 2018 for Client #1 showed he successfully turned on the water five times in a row during the first week of November. Client #1 was not successful the next twelve times in November.

Review of Client #1's file did not show an analysis of why he was successful in the beginning of November and unsuccessful the rest of the month.

2. Record review of Client #1's file showed the facility discontinued step one of the handwashing program on 12/05/18 after Client #1 was unsuccessful 14 times in a row. The facility implemented training on the next step of handwashing on 12/29/18, even though Client #1 failed to learn the prior step, and did not analyze

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{W 159}	Continued From page 18 the program to determine its effectiveness. During an interview on 01/10/19 at 10:03 AM, Staff AA, QIDP, was asked why Client #1 progressed in his handwashing program when he failed to meet the criteria to progress. Staff AA gave no response. Staff Z, Attendant Counselor Manager (ACM), stated that she made the decision to move him to the next step and the QIDP did not know or approve of the change. 3. Record review of Client #1's QIDP Review for June-July 2018 showed, "[Client #1's first name] progress towards reaching his goals have been extremely low." Record review of Client #1's August-September 2018 QIDP Review for a handwashing program showed, "Will need to reassess program as he has met criteria for failure," as he was not successful once in September. The program criteria for change was identified as no success in six data sessions. The review did not analyze why the Client was not successful in learning the skill, and made no changes to the program. Record review of Client #1's October-November 2018 QIDP review for the same handwashing program showed, "Criteria for failure met." The program criteria for change was identified as no success in six data sessions. The review did not analyze why the Client was not successful in learning the skill, and made no changes to the program. During an interview on 01/09/19 at 1:51 PM, Staff AA, QIDP, stated that she did not modify his program because she hoped he would progress.	{W 159}		

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{W 159}	Continued From page 19	{W 159}		

Incorrect assessment and lack of assessment

Record review of Client #3's Attendant Counselor Client Assessment, dated 06/30/18, showed a description of Client #3's money handling skills under the heading of Communication of Basic Needs section. There was no assessment of his communication in any section of the Attendant Counselor Client Assessment.

During an interview on 01/08/19, at 10:34 AM, Staff N, Attendant Counselor Manager (ACM), stated that the information for Client #3's Money Handling Skills section was copied and pasted erroneously into the Communication of basic Needs.

During an interview on 01/09/19, at 6:30 PM, Staff K, QIDP, and Staff N, ACM, stated that the Communication of Basic Needs section of the Attendant Counselor Client Assessment, dated 06/30/18, was not accurate and that it was an error.

Unaware of pending discharge

Review of Client #5's file showed no documentation regarding a pending discharge from the facility.

During an interview on 01/10/18 at 11:30 AM, Staff L, Psychology Associate, stated that Client #5's discharge was pending as the facility determined he did not qualify for Intermediate

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{W 159}	Continued From page 20 Care Facility services. During an interview on 01/10/19 at 3:55 PM, Staff AA, QIDP, stated that she was unaware of Client #5's pending discharge from the facility. Did not follow up on concerns identified in Q review Record review of Client #5's October 2018 QIDP Review, dated 11/27/18, (completed by the prior QIDP) showed: the facility discontinued an eating skill program due to lack of participation, Client #5 was not attending an Adult Training Program, and data was missing from two programs. The QIDP requested the ACM address the issues by 12/11/18. Review of Client #5's file showed no follow up assessment or documentation of the issues identified in the October 2018 QIDP Review. During an interview on 01/10/19 at 11:30 AM, Staff AA, QIDP, stated that she had not completed the QIDP Review or reviewed the prior QIDP reports. She did not know there were issues identified in the prior QIDP Reviews. No instruction for 1:1 staffing Record review of Client #5's IHP, dated 05/31/18, showed 1:1 staffing (one staff assigned solely to him to provide care) with line of sight supervision during waking hours. The IHP did not provide a rationale or instructions for Direct Care Staff	{W 159}		

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{W 159}	Continued From page 21 related to his need to have a designated staff member assigned to him. During an interview on 01/10/18 at 11:30 AM, Staff Y, ACM, stated that Client #5 required a designated staff assigned to him because he had an extensive history of falls. When asked if the IHP had instructions for staff related to falls, she stated that it did not. Documents not current in all areas Record review of Client #6's file at the Columbia Learning Center showed an IHP, dated 12/12/17, and a Positive Behavior Support Plan (PBSP), also dated 12/12/17. Record review of Client #6's IHP provided by the facility showed it was dated 12/04/18. Record review of an IHP Revision, dated 12/12/17, showed, "The IDT [Interdisciplinary Team] determined [Client #6's first name] is no longer in need of a positive behavior support plan (PBSP)." During an interview on 01/10/19 at 2:41 PM, Staff K, QIDP, stated that Client #6 no longer had a PBSP. She also stated that it takes a while for the new IHP to get to everyone. During an interview on 01/11/19 at 8:42 AM, Staff OO, ATS2, stated that the QIDP would let his supervisor know when there was a new IHP in the electronic file, then he would print it out.	{W 159}		

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{W 159}	Continued From page 22 Additional QIDP issues Observation, record review, and interview showed the QIDP failed to ensure four of six Sample Clients (Clients #1, #2, #3, and #5) were engaged in continuous active treatment that addressed skills essential to increasing their independence. See W196 for details. Record review and interview showed the QIDP failed to ensure one of six Sample Clients (Client #4) had accurate assessments completed to allow for implementation of training specific to the needs of the Client. See W210 for details. Record review and interview showed the QIDP failed to identify formal training for a challenging behavior for one of six Sample Clients (Client #3). See W227 for details. Observation, record review, and interview showed the QIDP failed to ensure three of six Sample Clients (Clients #1, #3, and #6) and one Expanded Sample Client (Client #7) had training programs that provided clear directions for staff to implement the programs consistently. See W234 for details. Record review and interview showed the QIDP failed to ensure data collection with a frequency that would determine program progress for two of six Sample Clients (Client #1 and #4). See W237 for details. Record review and interview showed the QIDP did not provide training for inappropriate behavior for one Expanded Sample Client (Client #7). See W239 for details.	{W 159}		

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{W 159}	Continued From page 23	{W 159}		

Record review and interview showed the QIDP failed to ensure there was training in personal care and communication of basic needs for four of six Sample Clients (Client #1, #3, #5, and #6). See W242 for details.

Record review and interview showed the QIDP failed to ensure all staff had access to one of six Sample Clients' (Client #6) Individual Habilitation Plan. See W248 for details.

Record review and interview showed the QIDP failed to provide only one Active Treatment Schedule for one of six Sample Clients (Client #6). See W250 for details.

Observation, record review, and interview showed QIDP failed to ensure staff implemented programs as written for five of six Sample Clients (Client #1, #2, #3, #5, and #6). See W251 for details.

Observation, record review, and interview showed the QIDP failed to ensure staff correctly recorded data for one Expanded Sample Client (Client #7). See W252 for details.

Record review and interview showed the QIDP failed to modify or change programs for three of six Sample Clients (Client #1, #3, and #4) after they achieved a training objective. See W255 for details.

Observation, record review, and interview showed the QIDP failed to ensure two of six Sample Clients (Clients #1 and #2) had their programs reviewed and revised when they failed to progress toward the objective. See W257 for details.

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{W 159}	Continued From page 24 Observation, record review, and interview showed the QIDP failed to review/update annual assessments for three of six Sample Clients (Client #2, #3, and #4). See W259 for details. Observation, record review, and interview showed the QIDP failed to ensure one of six Sample Clients (Client #3) had a training program to use and maintain his prescription glasses. See W436 for details.	{W 159}		
{W 186}	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: This regulation was not reviewed as part of the Focused Fundamental Survey for 01/15/19. It remains out of compliance from the 05/31/17 Survey and the 06/29/18 Survey.	{W 186}		
{W 193}	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: This regulation was not reviewed as part of the	{W 193}		

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{W 193}	Continued From page 25 Focused Fundamental Survey for 01/15/19. It remains out of compliance from the 06/29/18 Survey.	{W 193}		
{W 195}	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure six of six Sample Clients (Clients #1, #2, #3, #4, #5 and #6) and one Expanded Sample Client (Client #7) received all components of Active Treatment to meet their needs. This failure resulted in Clients not receiving training to increase their independence and potentially prolonged their move to the community. This is a repeat citation from the 05/31/17 and 06/29/18 surveys. Findings included ... Observation, record review, and interview showed the facility failed to ensure four of six Sample Clients (Clients #1, #2, #3, and #5) were engaged in continuous active treatment that addressed the major life skills essential to increasing their independence. See W196 for details. Record review and interview showed the facility failed to ensure one of six Sample Clients (Client #4) had accurate assessments completed to allow for implementation of training specific to the	{W 195}		

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{W 195}	Continued From page 26	{W 195}		

needs of the Client. See W210 for details.

Record review and interview showed the QIDP failed to identify formal training for a challenging behavior for one of six Sample Clients (Client #3). See W227 for details.

Observation, record review, and interview showed the facility failed to ensure three of six Sample Clients (Clients #1, #3, and #6) and one Expanded Sample Client (Client #7) had training programs that provided clear directions for staff to implement the programs consistently. See W234 for details.

Record review and interview showed the facility failed to ensure data collection with a frequency that would determine program progress for two of six Sample Clients (Client #1 and #4). See W237 for details.

Record review and interview showed the facility did not provide training for inappropriate behaviors for one Expanded Sample Client (Client #7). See W239 for details.

Record review and interview showed the facility failed to provide training in personal care and communication of basic needs for four of six Sample Clients (Client #1, #3, #5, and #6). See W242 for details.

Record review and interview showed the facility failed to ensure all staff had access to one of six Sample Clients' (Client #6) Individual Habilitation Plan. See W248 for details.

Record review and interview showed the facility failed to provide a singular Active Treatment

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{W 195}	Continued From page 27 Schedule for one of six Sample Clients (Client #6). See W250 for details. Observation, record review, and interview showed staff failed to implement programs as written for five of six Sample Clients (Client #1, #2, #3, #5, and #6). See W251 for details. Observation, record review, and interview showed the facility failed to ensure staff correctly recorded data for one Expanded Sample Client (Client #7). See W252 for details. Record review and interview showed the facility failed to progress three of six Sample Clients (Client #1, #3, and #4) after they achieved a training objective. See W255 for details. Observation, record review, and interview showed the facility failed to ensure two of six Sample Clients (Clients #1 and #2) had their programs reviewed when they failed to progress toward the objective. See W257 for details. Observation, record review, and interview showed the facility failed to review/update annual assessments for three of six Sample Clients (Client #2, #3, and #4). See W259 for details. Observation, record review, and interview showed the facility failed to ensure one of six Sample Clients (Client #3) had a training program to use and maintain his prescription glasses. See W436 for details.	{W 195}		
{W 196}	ACTIVE TREATMENT CFR(s): 483.440(a)(1) Each client must receive a continuous active	{W 196}		

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{W 196}	Continued From page 28 treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure four of six Sample Clients (Client #1, #2, #3, and #5) received Active Treatment in accordance with their needs. This failure prevented Clients from receiving training to increase their independence and potentially prolonged their discharge to a community setting. This is a repeat citation from the 05/31/17 and 06/29/18 surveys. Findings included ... Client #3 Review of Client #3's Comprehensive Functional Assessment (CFA), dated 07/10/18, showed Client #3 had a primary need for communication, and his core needs were: home-care skills; self-care skills; and active engagement.	{W 196}		

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{W 196}	Continued From page 29	{W 196}		

Record review of Client #3's file, on 01/07/19, showed Client #3 had four programs: point to a picture; shave two strokes of his face; cut food on his plate at meal times; and sign in a book for his money. There were no other programs to address his primary and core needs.

Observation on 01/07/19 from 1:42 PM - 2:54 PM at Building 2010, Room B01, an Adult Training Program (ATP) class, showed staff did not implement any training related to his needs identified in his Individual Habilitation Plan (IHP) during this time.

Observation on 01/08/19 from 7:34 AM - 10:45 AM at Haddon House, showed a Direct Care Staff (DCS) attempted to run a program from 9:10 AM - 9:22 AM but did not implement any training related to Client #3's needs identified in his IHP for the remainder of the time. From 1:10 PM - 1:57 PM, DCS did not implement any training related to his needs identified in his IHP during this time.

Observation on 01/09/19 from 11:44 AM - 1:02 PM at Haddon House, showed a DCS ran a program from 12:39 PM - 12:40 PM, but did not implement any training related to Client #3's needs identified in his IHP for the remainder of the time. From 1:20 PM - 2:15 PM at Building 2010, Room B01, staff did not implement any training related to Client #3's needs identified in his IHP during this time.

During an interview on 01/10/19 at 1:30 PM, Staff

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{W 196}	Continued From page 30 K, Qualified Intellectual Disability Professional (QIDP), and Staff M, Speech Language Pathologist (SLP), were asked if Client #3 could benefit from additional programs. Staff K stated that Client #3 had enough programs. Staff M stated that Client #3 would benefit from additional training programs in communication. Client #1 Record review of Client #1's CFA, dated 12/12/18, showed he required staff assistance to complete bathing, grooming, dressing, eating, toileting, household chores, and oral hygiene. Record review of Client #1's IHP, dated 07/12/18, showed no training programs or instructions for staff in relation to training for the identified needs. Record review of Client #1's Communication Evaluation, dated 06/29/18, showed recommendations for communication programs to expand his receptive language and communicative response. Record review of Client #1's IHP, dated 07/12/18, showed no training programs or instructions for staff in relation to training for the identified needs. Record review of Client #1's Dental Assessment, dated 01/11/18, showed poor dental hygiene, the need for improved daily oral hygiene, and staff were to help with brushing his teeth twice daily. Record review of Client #1's IHP, dated 07/12/18, showed there were no meaningful relevant training programs or instructions for staff in the IHP related to his training needs.	{W 196}		

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Record review of Client #1's IHP, dated 07/12/18, showed a primary need to increase his ability to initiate or self-start his actions to increase independence. The facility identified his core needs as activity engagement, Activity of Daily Living, socialization, and communication.

Record review of Client #1's training programs for January 2019 showed a total of five training objectives. Client #1 was to place a block on a peg with full physical assistance from staff, place a hand under running water, chose a 2nd portion of a meal by looking at it, follow staff direction to go to an activity, and touch a paper denomination to his pocket. There were no other training programs for the needs the facility identified in the CFA, IHP, or Dental Assessment.

Observation at Room B04 in the PAT A Headquarters Building (an ATP Program) on 01/09/19 from 9:01 AM-10:56 AM showed that training related to his identified needs was not observed.

During an interview on 01/10/19 at 10:03 AM, Staff Z, Attendant Counselor Manager (ACM), stated that the training programs addressed most of Client #1's needs.

Client #5

Record review of Client #5's Attendant Counselor Client Assessment, dated 05/20/18, showed he required staff assistance to complete toileting, personal hygiene, dental hygiene, eating, bathing,

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dressing, grooming, and communication of basic needs. Record review of Client #5's IHP, dated 05/31/18, showed no training programs for the identified needs.

Record review of Client #5's Communication Evaluation, dated 05/30/18, showed recommendations for communication programs to increase his engagement, increasing his attention to objects and pictures in his environment, and learning to distinguish between finger foods and foods that require utensils. Record review of Client #5's IHP, dated 05/31/18, showed no training programs for the identified needs.

Record review of Client #5's IHP, dated 05/31/18, showed Client #5 was assigned a designated staff to provide 1:1 supervision (one staff assigned to one Client) while Client #5 was awake. The facility identified Client #5's prioritized needs as training in communication, socialization, being involved in his self-care, and encouragement to be as independent as possible. The core needs identified included communication, socialization, and self-care. Client #5's IHP showed one training program for socialization (to shake three peoples' hands) and one self-care program (to wash one side of his face). He had a skill maintenance program for raising his arms and legs while staff dressed him. There were no other programs for the identified needs.

Observation at Devenish House on 01/07/19 from 7:22 AM-10:30 AM showed staff did everything for Client #5 and no training related to his identified needs was observed.

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{W 196}	Continued From page 33 During an interview on 01/10/19 at 11:30 AM, Staff AA, QIDP, Staff Y, ACM, and Staff L, Psychology Associate, stated that Client #5 did not have many training programs due to his history of refusal. When asked if his IHP reflected opportunities for implementation of active treatment throughout the day they stated that it did not, due to his resistant behaviors. Client #2 Record review of Client #2's IHP, dated 01/30/18, showed, "Core Needs: Socialization, Community Awareness, ADL's (Adult Daily Living Skills)." Record review of Client #2's training programs showed that he had five formal programs that data was being taken on. Program 1119.2 Client #2 would ring out the mop head for 10 of 12 data sessions. Program 1037.1 Client #2 would close the bathroom door for privacy. He also had a program to secure money in his pocket when he was going to the coffee shop, a program to choose a meal from a picture menu at the coffee shop, and a program to self-transport to his day training class. Observation on 01/07/19 from 1:50 PM - 2:53 PM at PAT A Activity Room showed Client #2 painted a garden tile and placed several fuzzy balls on top of a box lid. Observation on 01/08/19 from 8:16 AM - 8:40 AM at [redacted] House showed Client #2 sat at a table and strung large foam beads on to a string, took them off and then restrung them. Observation on 01/08/19 from 8:58 AM - 10:47 AM showed Client #2 was in PAT A Headquarters, Room B26, for Adult Training. While in Room	{W 196}		

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{W 196}	Continued From page 34 B26, Client #2 sorted through cards, sorted square chips by color, and threw one ball into a bin. No training occurred related to his training needs during these observations. During an interview on 01/08/19 at 9:25 AM, an Adult Training Specialist stated that one of the goals for the class was community and social engagement. When asked how many Clients attended the class, she stated that one other Client was enrolled but did not regularly attend. When he did attended he preferred to sit in a chair off to the side. During an interview on 01/10/19 at 2:00 PM, Staff J, QIDP, stated that ADLs were an identified need for Client #2 but that at this time that was addressed informally. She said his socialization was addressed by going to Adult Training five days a week. She did not know that there was only one other Client in his class who did not often attend and when he did, he sat off to the side by himself. She stated she was trying to slowly expand his community awareness by having Client #2 help with the food cart and with trips to the coffee shop. When asked if she felt Client #2 had enough programs to fill his day and aggressively teach him skills she stated, "No, I feel like he needs more programs."	{W 196}		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.	W 210		

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W 210	Continued From page 35 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure assessments for one of six Sample Clients (Client #4) were current and accurate. This failure resulted in inaccurate information for the facility to develop supports and training for the Client. Findings included ... 1. Record review of a Quarterly Nursing Exam and NCP [Nursing Care Plan] Review, dated 11/25/18, and a Yearly Nursing Exam and NCP Review, dated 10/02/18, showed Client #4 had eyeglasses and he tolerated them for short periods. Observations on 01/07/19 at 2:28 PM, 01/08/19 from 8:30 AM - 10:34 AM, and 01/09/19 at 5:45 PM at [redacted] showed Client #4 did not wear eyeglasses. Observation on 01/08/19 from 1:08 PM - 2:04 PM at the Program Area Team (PAT) A building, Room B25, showed that Client #4 did not wear eyeglasses. During an interview on 01/14/19 at 1:45 PM, Staff E, Registered Nurse (RN), stated that Client #4 did not wear eyeglasses and the information on the Quarterly Nursing Exam and NCP Review, dated 11/25/18, and the Yearly Nursing Exam and NCP Review, dated 10/02/18, was incorrect. 2. Record review of a Comprehensive Functional Assessment of Physical Therapy, dated 11/25/18, showed Client #4 was unable to self-propel in his	W 210		

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W 210	Continued From page 36 wheelchair. Observations on 01/07/19 at 2:28 PM, 01/08/19 at 8:30 AM, and 01/09/19 at 5:45 PM at [redacted] showed that Client #4 self-propelled his wheelchair. During an interview on 01/14/19 at 9:15 AM, Staff D, Physical Therapist, stated that Client #4 did not self-propel his wheelchair when she completed the assessment. When told by the State Surveyor that Client #4's Individual Habilitation Plan (IHP) from 05/30/18 showed that he self-propelled his wheelchair, Staff D again stated that she did not see Client #4 self-propel when she did her assessment. 3. Record review of a Psychological Assessment signed on 06/14/18 showed Client #4 had no picture identification skills. Observation on 01/08/19 at 1:59 PM at Room B25 showed the staff asked Client #4 to look at two pictures and choose which activity he would like to do, and had him look at pictures in a book while staff read it to him. During an interview on 01/11/19 at 10:00 AM, Staff F, Psychology Associate, was asked how he had determined Client #4 had no picture identification skills. He stated that he did an observation of Client #4 using an iPad. He asked Client #4 to choose one of two pictures on the iPad. When shown the same picture he had chosen after a short time span, Client #4 pushed it away. When asked how he knew that it was a lack of picture identification, rather than no interest in continuing use of the iPad, Staff F had no response.	W 210		

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W 210	Continued From page 37 Record review of a Communication Evaluation, dated 05/29/18, showed that Client #4 demonstrated joint attention towards more structured tasks as picture cards and he attended to an iPad. Record review of the IHP, dated 05/30/18, showed that Client #4 graduated last year from making a choice from several pictures. 4. Record review of a Psychological Assessment, signed on 06/14/18, showed Client #4 was unable to identify affect (emotion) in himself and others. Observation on 01/08/19 at 9:28 AM and10:02 AM at [redacted] showed Client #4 sat in his wheelchair and made the manual sign for sad. The staff responded that she understood he was sad. During an interview on 01/11/19 at 10:00 AM, Staff F, Psychology Associate, was asked how he determined Client #4 was unable to identify affect in himself or others. Staff F responded, "Pretty much off of a previous assessment done by a licensed PhD who was qualified to assess it." When told by the State Surveyor that other assessments contradicted his assessment, Staff F let out a big sigh, sagged at the shoulders, bent forward, and looked at the floor. 5. Record review of a Psychological Assessment, signed on 06/14/18, showed that staff utilized a satiation diet as a protection measure for Client #4 related to his Pica (a psychological disorder characterized by an appetite for substances that are largely non-nutritive, such as ice; hair; paper;	W 210		

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W 210	Continued From page 38 drywall or paint; metal; stones or soil; glass; feces; and chalk) behaviors. During an interview on 01/11/19 at 10:00 AM, Staff F, Psychology Associate, could not explain what the satiation diet was, and stated it was a term used in a previous Occupational Therapy (OT) Assessment. When asked how staff were expected to implement this when there was no clear definition of what it was and how it was used, Staff F had no answer. Review of the two most recent OT Assessments, dated 07/17/17 and 06/08/17, did not contain the term, satiation diet.	W 210		
{W 227}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to identify formal training for a challenging behavior for one of six Sample Clients (Client #3). This failure resulted in the Client not receiving training for identified needs. This is a repeat citation from the 06/29/18 Post Survey. Findings included ...	{W 227}		

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{W 227}	Continued From page 39 Record review of Client #3's Comprehensive Functional Assessment, dated 07/10/18, showed Client #3 had a behavior described as walking around the house picking up lint and pieces of paper, and carrying it in his hands. The CFA showed that the behavior can be problematic because it creates a situation where he cannot use his hands. Record review of Client #3's Positive Behavior Support Plan (PBSP), dated 07/11/17, showed one of Client #3's challenging behaviors listed under Syndrome-Related Symptoms (9014) was, "Compulsive scanning of the environment for objects out of place and needing to be picked up off of the floor." There was no formal program for the assessed behavior. Observations on 01/07/19 from 1:42 PM to 2:54 PM at Building [redacted] on 01/08/19 from 7:34 AM to 10:46 AM at [redacted] House, and on 01/09/19 from 1:20 PM to 1:47 PM at [redacted] showed Client #3 frequently picked up small items from the floor and held them in his hand. During an interview on 01/09/19 at 6:30 PM, Staff L, Psychology Associate, stated that the PBSP did not contain any programs or directions to address Client #3's behavior of picking up lint and pieces of paper, and carrying it in his hands.	{W 227}		
W 234	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(i)	W 234		

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W 234	Continued From page 40 Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that three of six Sample Clients (Client #1, #3, and #6) and one Expanded Sample Client (Client #7) had teaching plans that contained detailed instructions for staff. This failure resulted in Clients not having staff across all shifts who had sufficient directions to ensure all Clients were taught the same way and collected data correctly. This is a repeat citation from the 05/31/17 survey. Finding included ... Client #3 Record review of Client #3's Nutritional Assessment Update, dated 01/03/19, showed staff were to salt his food liberally. Record review of Client #3's Comprehensive Functional Assessment, dated 07/10/18, and Individual Habilitation Plan, dated 07/10/18, showed Client #3 had [redacted] and the recommendation was to liberally salt his food.	W 234		

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W 234	Continued From page 41 Record review of Client #3's Eating Guidelines from the dining book, dated 12/05/18, showed to salt his food liberally. Observation on 01/09/19 at 11:20 AM and at 5:15 PM at Haddon House showed Client #3 got and ate his meals. Direct Care Staff (DCS) did not salt his food. During an interview on 01/09/19 at 6:30 PM, Staff L, Qualified Intellectual Disability Professional (QIDP), and Staff N, Attendant Counselor Manager (ACM), stated that Client #3's Eating Guidelines did not give specific directions on how much salt should be added to Client #3's food. Client #3 Record review of Client #3's Program #1093.5, dated 12/18/18, showed, "With 2 verbal cues and gesture, [Client #3's first name] will shave (2 strokes) the side of his face for 7 out of 10 data sessions." The positioning of Staff/Client showed, "Staff on either side of [Client #3's first name]." The program did not state which side of Client #3's face he was to shave or which side of Client #3 staff were to stand on to ensure consistent program implementation. During an interview on 01/11/19, at 1:30 PM, Staff K, QIDP, stated that Client #3 can shave whatever side of his face he chose and that staff can stand on either side of Client #3.	W 234		

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W 234	Continued From page 42	W 234		

Client #1

Record review of Client #1's IHP Revision, dated 01/07/19, showed a relationship development program where staff would place Client #1's hand on their hand or arm when he initiated inappropriate contact. A definition of inappropriate contact was not included in the program.

During an interview on 01/11/19 at 11:23, Staff BB, Psychologist, stated that the program needed more detailed information for staff.

Client #6

Record review of Client #6's Program #1079.1 Put shoe away showed, "With one verbal cue and hand on hand assistance, [Client #6's first name] will locate his shoe basket for 7 out of 10 data sessions." The Program Cue showed staff asked Client #6 to take his shoe to his room. There was no mention of Client #6 locating his shoe basket. The program reinforcer instructed staff to say, "[Client #6's first name], I like the way you take care of you shoes." There was no mention of where the shoe basket was located. Data was taken on whether Client #6 carried his shoes to his room, but not for locating the shoe basket.

Record review of Client #6's Program #1125.1 showed, "With two verbal cues, hand on wrist assist and model (staff wash cup with sponge, [Client #6's first name] will wash a cup for 7 out of 10 data sessions." The Teaching Sequence failed to identify how Client # 6 acquired a sponge and

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W 234	Continued From page 43 who turned on the water. The data scoring instructions included information regarding Client #6 washing the cup and, taking his shoes to his room. During an interview on 01/11/19 at 10:12 AM, Staff K, QIDP, stated that she had recently took over writing the training objectives and may have missed some details. Client #7 Review of Client #7's file showed a form that staff would document data on for whether or not he engaged in his sensory programs. In the lower data box was a program to take Client #7 to the gross motor room for sensory stimulation once a week. Above the data box was listed, "Data Day: Daily on AM and PM shift," instructing staff to take data daily on both AM and PM shifts. During an interview on 1/14/19 at 11:40 AM, Staff J, QIDP, stated that the sheet was confusing and the instructions were unclear.	W 234		
W 237	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(iv) Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the data collected for two	W 237		

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W 237	Continued From page 44 of six Sample Clients (Clients #1 and #4) was sufficient to determine the rate of learning. This failure resulted in an inaccurate reflection of the progress, or lack of progress, Clients made on their training objectives. This is a repeat citation from the 05/31/17 survey. Findings included ... Client #1 Record review of Client #1's teaching programs showed staff were to collect data two times a week, once on the AM shift and once on the PM shift. The teaching programs instructed staff to implement the training each day on each shift. Review of the data sheets for Client #1 by the State Surveyor showed he was not consistently successful nor unsuccessful in his training programs. During an interview on 01/10/19 at 10:03 AM, when asked if staff should collect data each time they implemented the program, Staff Z, Attendant Counselor Manager, stated that staff collected data as often as needed to determine success. If staff collected data more often, the Client would fail the program more quickly. When asked how she analyzed the data from a small sample, Staff Z did not respond. Client #4 Review of Client #4's file showed four current programs: #2073.4; #1129; #2071; and #2081 that directed data be taken twice weekly, once on the AM (day) shift and once on the PM (late afternoon/evening) shift. The file showed one	W 237		

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W 237	Continued From page 45 current program, #1139.2, that required data to be taken twice weekly on the AM shift and twice weekly on the PM shift. All of these programs required correct implementation for eight out of 10 data sessions in order to progress. Program #2073.4 began on 06/28/18 and #2081 began on 09/11/18. The State Surveyor determined the soonest Client #4 could have a program change would be four weeks for the first four programs, and two weeks for Program #1139.2 assuming he successfully completed the objective each time. Once the facility determined if he had progressed or not in Program #1139.2 for their identified two weeks, they then ignored that data and started over again to see if Client #4 could be successful for eight data sessions in the next two weeks. By not analyzing data in any ten consecutive sessions, Client #4 continued to be trained on a program he had shown success in per the requirement identified in the plan. Client #4 started this training plan on 06/02/18. During an interview on 01/10/19 at 1:30 PM, Staff B, Qualified Intellectual Disabilities Professional (QIDP), and Staff C, Attendant Counselor Manager (ACM), stated that they believed data taken twice a week was enough to analyze it accurately.	W 237		
W 239	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(vi) Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if	W 239		

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W 239	Continued From page 46 applicable, with behavior that is adaptive or appropriate. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to identify and teach functional skills to replace inappropriate behaviors for one Expanded Sample Client (Client #7). This failure prevented Client #3 from learning how to substitute a more constructive alternative behavior for an inappropriate behavior. This is a repeat citation from the 05/31/17 survey. Findings included ... Record review of Client #7's Positive Behavior Support Plan (PBSP), dated 11/29/18, showed the inappropriate behaviors to be decreased were Self-Injurious Behavior (SIB), agitation, and inappropriate removal of clothing. The PBSP showed he engaged in these behaviors when his environment was disrupted, or when he was ill or in pain. The PBSP showed one replacement behavior, "[Client #7's first name] will choose between two sensory items to increase his interest in his environment. He will do this with 70% success for 5 out of 6 consecutive months." There was no replacement behavior related to the function of illness or pain. During an interview on 01/14/19 at 11:00 AM, Staff F, Psychology Associate, stated that sometimes Client #7 engaged in SIB sometimes because he was in pain or because he was	W 239		

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W 239	Continued From page 47 experiencing sensory distress due to his environment. When asked if the function was the same for all challenging behaviors, Staff F contradicted his previous statement and written assessment and stated that all his behaviors were related to sensory issues.	W 239		
{W 242}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide training in personal care skills and communication of basic needs for four of six Sample Clients (Clients #1, #3, #5, and #6). This failure prevented Clients from improving their personal care skills and communication skills. This is a repeat citation from the 06/29/18 survey. Findings included ... Client #6 Record review of Client #6's Comprehensive Functional Assessment (CFA), dated 12/11/18, identified the need for full physical assistance or partial physical assistance from staff with bathing, toileting, personal hygiene, shaving, and	{W 242}		

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{W 242}	Continued From page 48 dressing. Record review of Client #6's Individual Habilitation Plan (IHP), dated 12/04/18, showed he had two formal training programs related to the teaching self-care skills. The training programs included locating his shoe basket and placing his thumbs inside the neck of his sock. The IHP did not include training objectives or instructions for staff to teach Client #1 how to care for his own personal needs with the exception of dressing. During an interview on 01/10/19 at 2:44 PM, Staff K, Qualified Intellectual Disability Professional (QIDP), stated she prioritized the shoe and sock training program because Client #6 liked to take them off and it helped to clean up his home environment. Client #3 Record review of Client #3's Dental Assessment, dated 07/03/18, and Annual Healthcare Assessment, dated 06/29/18, showed Client #3 needed overall improved daily hygiene care. Record review of Client #3's Individual Habilitation Plan (IHP), dated 07/10/18, showed there was no dental hygiene program. During an interview on 01/10/19 at 1:30 PM, Staff K, QIDP, stated that Client #3's dental hygiene training was a low priority at this time. Client #1 Record review of Client #1's CFA, dated	{W 242}		

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{W 242}	Continued From page 49	{W 242}		

12/12/18, showed staff provided physical assistance to complete Client #1's toileting, personal hygiene, dental hygiene, eating, bathing, dressing, and grooming.

Record review of Client #1's Communication Evaluation, dated 06/29/18, showed recommendations for communication programs to expand his receptive language skills, improve his ability to understand and communicate his medical needs, and to create reliable and intentional communicative responses.

Record review of Client #1's Dental Assessment, dated 01/11/18, showed Client #1, "Needs overall improved daily hygiene care." It identified his oral hygiene as poor and showed that his oral tissues were red, puffy, and bleeding.

Record review of Client #1's IHP, dated 07/12/18, did not include training objectives or instructions for staff to teach Client #1 how to care for his own personal needs.

Review of Client #1's program teaching plans for January 2019 showed no training objectives for the identified personal care needs.

During an interview on 01/10/19 at 10:03 AM, Staff Z, Attendant Counselor Manager (ACM), stated that he did not have programs to address the identified skill deficits identified in the CFA.

Client #5

Record review of Client #5's Attendant Counselor Client Assessment, dated 05/20/18, showed the facility identified that he was below basic skill level for completion of self-toileting, personal

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{W 242}	Continued From page 50 hygiene, dental hygiene, eating, bathing, dressing, grooming, and communication of basic needs. Record review of Client #5's Dental Assessment, dated 04/11/18, showed he had poor oral hygiene, pink and red tissue, heavy plaque and calculus on his teeth. Record review of Client #5's Communication Evaluation, dated 05/30/18, showed recommendations for communication programs centered around Client #5's need to increase engagement, increase attention to objects and pictures in his living unit, and understanding the difference between food eaten with hands versus eaten with silverware. Review of Client #5's IHP, dated 05/31/08, did not address training to improve communication or his personal self-care tasks. The IHP did not contain documentation indicating Client #5 was unable to learn personal care skills or alternate ways to communicate his basic needs. During an interview on 01/10/18 at 11:30 AM, Staff Y, ACM, stated that Client #5 did not have a current dental hygiene training program.	{W 242}		
W 248	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.	W 248		

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W 248	Continued From page 51 This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure one of six Sample Clients' (Client #6's) current Individual Habilitation Plan (IHP) was available to all staff who worked with him. The facility also failed to ensure Client #6's Positive Behavior Support Plan (PBSP), which was discontinued, was removed from all settings. This failure could result in Client #6 not receiving consistent training from staff. Client #6 Record review of Client #6's file at the [redacted] showed an IHP dated 12/12/17 and a PBSP also dated 12/12/17. Record review of Client #6's IHP provided by the facility was dated 12/04/18. Record review of an IHP Revision, dated 12/12/17, showed, "The IDT [Interdisciplinary Team] determined [Client #6's first name] is no longer in need of a positive behavior support plan (PBSP)." During an interview on 01/10/19 at 2:41 PM, Staff K, Qualified Intellectual Disability Professional, stated that Client #6 no longer had a PBSP. She also stated that it took time for the new IHP to get out to everyone. During an interview on 01/11/19 at 8:42 AM Staff OO, Adult Training Specialist 2, stated that the QIDP would let his supervisor know when there was a new IHP in the electronic file and then he would print it out.	W 248		

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W 250	Continued From page 52	W 250		
W 250	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(2) The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of six Sample Clients (Client #6) had a single Active Treatment Schedule available for Direct Care Staff (DCS). This failure could result in staff being unsure about what Client #6 should be doing over the course of his day. This is a repeat citation from the 05/31/17 survey. Findings included ... Review of Client #6's post book (book used by staff that described his schedule and training programs) at [redacted] House showed two different Active Treatment Schedules, one dated 04/03/18 and one dated 06/04/18. During an interview on 01/08/19 at 9:56 AM, Staff R, DCS, stated that one Active Treatment Schedule was old and slightly different. Staff R indicated the current Active Treatment Schedule was the one dated 04/03/18.	W 250		
W 251	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(3) Except for those facets of the individual program	W 251		

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W 251	Continued From page 53 plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure Individual Habilitation Plans (IHPs) and training programs were implemented correctly for five of six Sample Clients (Clients #1, #2, #3, #5, and #6). This failure resulted in inconsistent training, no training, and potential health risks associated with dietary needs. Client #1 Eating protocol Observation at [redacted] House on 01/09/19 at 11:53 AM showed staff poured apple juice into a nosey cup filling it approximately ¾ of the way full. At 11:54 AM, staff refilled the glass to the edge of the opening for the nose. At 11:56 AM, a whole tater tot fell off Client #1's spoon while he was eating. Record review of Client #1's eating protocol, dated 07/02/18, showed food should be in ¼ inch pieces and liquids should be served ½ glass at a time. During an interview on 01/09/19 at 11:55 AM, Staff MM, Food Service Worker (FSW), stated that staff were responsible for mashing the tater tot to alter it to the appropriate texture.	W 251		

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W 251	Continued From page 54 During an interview on 01/09/19 at 12:05 PM, Staff MM, FSW, stated that Client #1's cup should be filled half full. Client #2 Observation on 01/07/18 from 7:58 AM - 8:15 AM at Buckley House showed Client #2 ate breakfast. He drank juice from a plastic cup filled ¾ full. A Direct Care Staff (DCS) reminded him several times to keep drinking from his cup. Observation on 01/09/18 at 11:16 AM at Buckley House showed Client #2 ate lunch. He poured juice from a pitcher into his plastic cup up to the fill line. A DCS reminded him to drink in between bites. Record review of Client #2's Eating Protocol, dated 05/11/18, showed staff were to provide two ounce portions of liquid at a time. It also showed instruction for staff to provide intermittent positive reinforcement for taking a small drink and to provide a communication opportunity to request more to drink by having Client #2 exchange a picture to make a request. During an interview on 01/09/18 at 11:25, A DCS stated that Client #2 had to be reminded to take drinks and that he had to drink at least two ounces at a time. During an interview on 01/10/18 at 2:00 PM, Staff J, Qualified Intellectual Disability Professional, stated that Client #2's Eating Protocol indicated that he was to only have two ounces of liquid at a time because he had been drinking rapidly. She	W 251		

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acknowledged that he no longer needed to be restricted to two ounces of liquid at a time and stated that his Eating Protocol should be revised.

Client #3

Record review of Client #3's Communication training plan 2080.1, dated 08/21/18, showed the objective, "[Client #3's first name] will point towards a single picture or a communication board that represents a desired object for 8 out of 10 data sessions." This training plan was to be implemented daily. The Staff/Client positioning and teaching sequence for this objective showed staff were to stand next to Client #3 in front of the communication board, show him the pictures on the communication board, and cue him to point to what he wanted.

Observation on 01/08/19 at 7:35 AM - 10:35 AM at Haddon House showed a DCS assisted Client #3 to pour his milk and filled his cup with water. They repeatedly asked Client #3 if he wanted water, juice, or coffee. At no time did a DCS implement his 2080.1 Communication Program.

During an interview on 01/11/19 at 11:50 AM, Staff N, Attendant Counselor Manager (ACM), the State Surveyor described the observation on 01/08/19 to Staff N, Attendant Counselor Manager (ACM) and asked if Client #3's 2080.1 Communication Program should've been run. Staff N stated that yes, it should have.

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W 251	Continued From page 56 Observation on 01/08/19 at 9:16 AM at Haddon House showed Staff N, ACM, gave Client #3 two dollars and stated, "We have to go sign for it." At 9:17 AM, Staff N, placed a book on Client #3's lap and placed a pen in his hand. She stated, "It says you have two dollars," and he put the pen on the paper. Staff N said thank you and walked away from Client #3 Record review of Client #3's money management program Objective 1160.1, dated 01/03/19, showed that DCS were to provide two verbal cues, model signing their name on paper, and then place their hand under Client #3's forearm to assist him in writing his name. The next step was for DCS to give Client #3 the money and request he put it into his pocket. During an interview on 01/08/19 at 9:22 AM, Staff N, ACM, stated that she did not implement Client #3's program as written. Client #5 Dining protocol Observation at [redacted] House on 01/08/19 at 7:57 AM showed Client #5 sat at a dining room table in front of a high-sided dish with yogurt and a Nutrigrain bar in it. Client #5 picked up a bite of the Nutrigrain bar with his right hand. Staff X, Attendant Counselor (AC), stated, "No," and shook Client #5's hand to make it fall back into the dish and stated, "Use your spoon." Client #5 reached his hand out again to pick up a bite of the Nutrigrain bar and Staff X stated, "No," and pulled Client #5's hand away from the dish.	W 251		

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W 251	Continued From page 57 Record review of Client #5's eating protocol, dated 06/20/18, showed finger foods should be placed in a separate dish and positioned on the right hand side if he was using his utensils with his left hand and vice versa. During an interview on 01/08/19 at 8:14 AM, Staff Y, ACM, stated that a Nutrigrain bar was a finger food and did not require silverware. At 3:55 PM, Staff Y stated that the finger foods should have been in a separate dish. Transfer Observation at [redacted] House on 01/08/19 at 8:54 AM showed S X, AC, transferred Client #5 from his wheelchair to a low bed that was approximately 12 inches from the floor. Staff X performed the transfer without a second staff member to assist and did not raise the height of the bed. Record review of Client #5's IHP Revision, dated 08/30/18, showed that Client #5 required the assistance of two staff for safety when transferring him to and from his bed and wheelchair. During an interview on 01/08/19 at 9:22 AM, Staff Y, ACM, stated that Client #5 required the assistance of two staff to transfer. Client #6 Food placement Record review of Client #6's IHP, dated 12/11/18, showed that staff should use an O'CLOCK Standard Table setting and diagram of meal placement for all mealtimes due to his impaired vision. The IHP included a diagram of where each food item should be placed in a divided bowl with	W 251		

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W 251	Continued From page 58 three sections placed in front of Client #6. The diagram indicated the main course should be in the 4:00 - 8:00 o'clock divided section, starchy food in the 12:00 - 4:00 o'clock divided section, and vegetables or green salad in the 8:00 - 12:00 o'clock divided section of the bowl. Observation at [redacted] House on 01/09/19 from 11:22 AM - 11:32 AM, showed Client #6 sat at the dining table with a highsided divided dish in front of him. A DCS brought a serving bowl which contained pureed tater tot casserole and cooked peas to the table. The staff provided hand over hand assistance to Client #6 to scoop the pureed casserole and peas from the bowl into two of the three divided sections of the highsided dish. The casserole and peas were comingled in each section. During the interview on 01/09/19 at 4:03 PM, Staff Q, ACM, was showed that the O'CLOCK diagram was in Client #6's IHP, and not in his diet book. She stated that she needed to put the diagram in the diet book and do an in-service training with the staff on the correct way to place Client #6's food. Textured Blocks Record review of Client #6's IHP, dated 12/11/18, showed that due to his impaired eyesight textured blocks were to be on the wall outside of Client #6's bedroom and bathroom to help him identify those areas. Observation at [redacted] House on 01/09/19 at 4:03 PM showed t e was no texture block outside of the bathrooms on A-side of the house near #6's bedroom. Staff Q, ACM, accompanied	W 251		

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W 251	Continued From page 59 the State Surveyor on this observation. During an interview on 01/09/19 at 4:03 PM, Staff Q, ACM, stated that there were no textured blocks by the bathrooms near Client #6's bedroom as stated in his IHP.	W 251		
{W 252}	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that the data required to analyze behavior was recorded correctly as identified in the Client's Individualized Habilitation Plan (IHP) for one Expanded Sample Client (Client #7). This failure prevented the facility from collecting and analyzing the data to determine the Client's progress or lack thereof. This is a repeat citation from the 05/31/17 and 06/29/18 surveys. Lack of data documentation Observation on 01/09/19 at 11:55 AM at [redacted] House showed that Client #7 laid on the floor, moaned at times, and hit himself in the chest. A Direct Care Staff (DCS) spoke to him calmly and asked him to stop hitting himself and discussed with Staff JJ, Licensed Practical Nurse (LPN) that	{W 252}		

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{W 252}	Continued From page 60	{W 252}		

Client #2 was having a difficult day.

Record review of Client #7's Interdisciplinary Progress Notes and Health Interdisciplinary Notes dated 01/09/19, showed that he had an incident of Self Injurious Behavior (SIB).

Record review of Client #7's Daily Behavior Summary for the month of January 2019 showed no indication that Client #7 had any SIB on 01/09/19.

Record Review of Client #7's Interdisciplinary Progress Notes for 12/21/18 showed that Client #2 hit the right side of his body with his hands.

Record Review of Client #7's Health Interdisciplinary Progress Notes for 12/25/18 showed that Client #2 hit his abdomen.

Record Review of Client #7's Daily Behavior Summary for the month of December 2018 showed no indication that Client #7 had any SIB on 12/21/18 and 12/25/18.

Record review of Rainier School Injury and Fall Assessments, dated 11/13/18 and 11/21/18, showed that Client #7 engaged in SIB behavior by hitting his head on the floor.

Record review of Client #7's Daily Behavior Summary for the month of November 2018 showed no indication that Client #7 had any SIB on 11/13/18 and 11/21/18.

Record review of Client #7's AC Nursing Order and Treatment Record showed an upper box where staff would initial if he had signs of increased agitation as he had a history of SIB. It

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{W 252}	Continued From page 61	{W 252}		

showed a box below for staff to initial if Client engaged in SIB and gave instructions for staff to offer him his soft helmet and refer to Client #7's Positive Behavior Support Plan. These boxes were blank for December 2018 and January 2019.

During an interview on 01/14/19 at 11:00 AM, Staff LL, Attendant Counselor Manager (ACM), did not know why there was missing data concerning Client #7's SIB. Staff M, Psychology Associate (PA), acknowledged that staff should record each instance of Client #7's challenging behaviors on the Daily Behavior Summary sheet.

During an interview on 01/11/19 at 10:34 AM at Buckley House, a DCS stated that it was the responsibility of Attendant Counselors (AC) to fill out the AC Nursing Order and Treatment Record. Staff NN, Registered Nurse, confirmed that AC's filled out the forms and then nursing reviewed them.

During an interview on 01/14/19 at 11:00 AM, Staff J, Qualified Intellectual Disability Professional (QIDP), acknowledged that the AC Nursing Order and Treatment Records were blank, and agreed that nursing would not get a clear picture to analyze pain versus SIB.

Sensory Programs

Record review of Client #7's Program for him to tolerate staff sitting next to him for at least 10 minutes showed that data was to be taken daily both AM shift and PM shift. For the month of December 2018 there were 62 opportunities for data collection and 15 times were not

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{W 252}	Continued From page 62 documented. Record review of Client #7's Program for staff to take him to the gross motor room for sensory stimulation, showed instructions for staff to document daily on AM shift and PM shift. For the month of December 2018 there were 62 opportunities for data collection and 22 times were not documented. During an interview on 01/14/19 at 11:00 AM, Staff LL, ACM and Staff J, QIDP could not explain the missing data.	{W 252}		
{W 255}	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure three of six Sample Clients (Clients #1, #3, and #4) progressed to another objective once they had achieved one. This failure resulted in Clients continuing training for skills they had learned and missed opportunities for them to learn other skills. This is a repeat citation from the 05/31/17 and 06/29/18 surveys. Findings included ... Client #1	{W 255}		

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{W 255}	Continued From page 63 Record review of Client #1's teaching plan for following a one-step direction, dated November 2018, showed that Client #1 successfully completed the objective for 10 of 12 data consecutive data sessions on 11/20/18. Client #1 did not receive a new training plan to learn to follow directions until January 2019. During an interview on 01/10/19 at 10:03 AM, Staff Z, Attendant Counselor Manager (ACM), stated that she started Client #1 on the next step in January, which was approximately six weeks after it was completed. Client #3 Record review of Client #3's Individual Habilitation Program (IHP), dated 07/10/18, showed a current training program Objective 1137.2 for a home-care skill of moving clean laundry from the dryer to the clothes basket. Record review of Client #3's Teaching Plan, dated 11/09/18, showed program Objective 1137.2, was completed on 12/10/18 with the criteria for success met, and no new objective was started. During an interview on 01/14/19 at 9:14 AM, Staff K, Qualified Intellectual Disability Professional (QIDP), and Staff N, ACM, stated that Client #3 completed Objective 1137 on 12/10/18. They stated that Client #3 did not have a new home-care skill program yet.	{W 255}		

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{W 255}	Continued From page 64 Client #4 Record review by the State Surveyor of the data collection sheet for Program #1139.2 showed it was to pick up a wet washcloth for eight out of 10 data sessions. The State Surveyor discovered Client #4 met the criteria for this objective on 12/25/18 (data from 12/11/18-12/25/19), and again on 01/01/19 (data from 12/18/18-01/01/19). During an interview on 01/10/19 at 1:30 PM, Staff B, Qualified Intellectual Disabilities Professional (QIDP), and Staff C, Attendant Counselor Manager (ACM), stated that they used pre-set dates to determine when Client #4 met the criteria, and he started over again for each identified time period. Staff C stated that they did not consider the data for any ten consecutive dates, only the ones already outlined on the data sheet. Staff C stated that to look at the data the way the State Surveyor did, by using any cluster of ten sessions, staff would have to check the data every day.	{W 255}		
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by:	W 257		

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W 257	Continued From page 65 Based on record review and interview the facility failed to review or revise programs for two of six sample Clients (Clients #1 and #2) after they failed to progress on identified objectives. This failure resulted in Clients not receiving training to meet their identified needs. This is a repeat citation from the 05/31/17 survey. Findings included ... Client #1 Record review of Client #1's program to turn on the water to wash his hands, dated July/August 2018, showed if he wasn't successful six times in a row the program must be changed. Client #1 was not successful 27 times in a row between August 16, 2018 and October 2, 2018. Record review of Client #1's November 2018 program to turn the water on to wash his hands showed he was unsuccessful 12 times in a row. Review of Client #1's file showed there was no analysis of his performance or documentation to indicate the program was changed when he was unsuccessful. Record review of Client #1's Qualified Intellectual Disability Professional (QIDP) Review, dated 10/02/18, showed the QIDP identified the need to reassess the program as he had met criteria for failure. Record review of Client #1's QIDP Review, dated 12/03/18, showed the QIDP identified that Client #1 required program modification due to being unsuccessful with the current program.	W 257		

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W 257	Continued From page 66 During an interview on 01/09/18 at 1:51 PM, Staff AA, QIDP, stated, "I guess I didn't modify it. I hoped he would progress." Client #2 Record review of Client #2's Program Objective #10.0, dated 11/01/18, showed it was to pair three sets of cards together for eight of ten data sessions. The criteria for failure was no change in six data sessions. The data recorded showed that Client #2 failed the objective in November 2018. During an interview on 01/10/19 at 10:41 AM, Staff U, Adult Training Specialist 3, stated that Client #2 failed Program Objective #10.0 in November and there was not a program to replace it. During an interview on 01/10/19 at 2:00 PM, Staff J, QIDP, stated that she did not know Client #2 had failed his objective for Program Objective #10.0.	W 257		
W 259	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure three of six Sample Clients (Clients #2, #3, and #4) had assessments that were updated and relevant.	W 259		

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W 259	Continued From page 67 This failure resulted in assessments that were inaccurate and not helpful to guide training for the Clients. This is a repeat citation from the 05/31/17 survey. Findings included ... Client #2 Record review of Client #2's Speech-Language Assessment Update showed it was dated 01/25/17. Observation on 01/09/19 from 11:50 AM - 2:25 PM at Buckley House, showed Staff M, Speech-Language Pathologist (SLP) and Staff KK, Speech Therapy Aide (STA), worked with Client #2 on a communication program. Staff KK and Staff M stated that Client #2 appeared to know some numbers and letters, which was different than previously assessed, and further assessment may be necessary. During an interview on 01/10/19 at 11:30 AM, Staff M stated that Client #2's Speech-Language Assessment Update, dated 01/25/17, was the most current on file. He stated he was currently working on a new one. During an interview on 01/10/19 at 2:00 PM, Staff J, Qualified Intellectual Disability Professional (QIDP), stated that Client #2's Speech Assessment was not current and was a couple of years old.	W 259		

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W 259	Continued From page 68 Client #3 Record review of Client #3's Comprehensive Functional Assessment Psychological Report, dated 07/11/17, identified behavior challenges as Self-Injurious Behavior (9001), Aggression (9002), and Syndrome related agitation (9014). During an interview on 01/14/19 at 2:38 PM, Staff L, Psychology Associate, was asked if the behavioral CFA was reviewed at the annual Individual Habilitation Plan (IHP) meeting. She stated that it had not, and Client #3 needed to be reassessed. Client #4 Record review of the most current Occupational Therapy Assessment, dated 07/17/17, showed Client #4 was living in [redacted] House. It showed he made progress in walking. Observations on 01/07/19 from 2:28 PM - 3:03 PM, 01/08/19 from 8:09 AM - 10:54 AM and 1:00 PM - 2:25 PM, and 01/09/19 from 5:45 PM - 6:37 PM at [redacted], where Client #4 lived, showed Client #4 was in a wheelchair. During an interview on 01/14/19 at 9:30 AM, Staff G, Occupational Therapist, stated that the previous Clinical Director would not allow the Occupational Therapists to work with Clients without a physician's referral. That person was now gone and she was working on assessing all the Clients now.	W 259		

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{W 320}	PHYSICIAN SERVICES CFR(s): 483.460(a)(2) The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care. This STANDARD is not met as evidenced by: This regulation was not reviewed as part of the Focused Fundamental Survey for 01/15/19. It remains out of compliance from the 06/29/18 Survey.	{W 320}		
{W 323}	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: This regulation was not reviewed as part of the Focused Fundamental Survey for 01/15/19. It remains out of compliance from the 06/29/18 Survey.	{W 323}		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assess one Expanded Sample Clients' (Client #8's) injury for the cause of the injury. This failure prevented the	W 331		

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W 331	Continued From page 70 facility from developing a plan to prevent re-injury to the Client. Findings included ... Observation at [redacted] House on 01/07/19 at 1:50 PM showed Client #8 sat in a recliner in the front room. He was not wearing socks or shoes. The fourth toe of his left foot appeared red and swollen. Observation at Devenish House on 01/08/19 at 1:32 PM showed Client #8 sat in a recliner in the front room. He was not wearing socks or shoes. The fourth toe of his left foot appeared more swollen than the day prior. Review of Client #8's file revealed a Health Interdisciplinary Progress Note, dated 01/05/19, that showed the toenail on his fourth toe of his left foot was coming off and staff notified nursing. A Nursing Note, dated 01/05/19, showed an assessment of the injury; however, a Fall and Injury Assessment form was not in the file. The file did not contain an assessment of how the injury may have occurred and did not address interventions to prevent the injury from happening again. During an interview on 01/08/19 at 1:52 PM, Staff Z, Attendant Counselor Manager, stated that she had not investigated the injury to Client #8's foot. During an interview on 01/14/19 at 9:25 AM, Staff EE, Registered Nurse (RN) Manager, and Staff FF, RN Manager, stated that the nurse that completed the assessment should have completed a Fall and Injury Assessment form. She also stated that there were no interventions	W 331		

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W 331	Continued From page 71 to prevent the injury from occurring again as staff did not know how the injury occurred.	W 331		
W 333	NURSING SERVICES CFR(s): 483.460(c)(2) Nursing services must include the development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure one Expanded Sample Client (Client #8) had a nursing care plan developed after an injury. This failure prevented Client #8 from having knowledgeable staff to monitor him during recovery. Findings included ... Observation at [redacted] House on 01/07/19 at 1:50 PM showed Client #8 sat in a recliner in the front room. He was not wearing socks or shoes. The fourth toe of his left foot appeared red and swollen. Observation at [redacted] House on 01/08/19 at 1:32 PM showed Client #8 sat in a recliner in the front room. He was not wearing socks or shoes. The fourth toe of his left foot appeared more swollen than the day prior. Review of Client #8's file revealed an Interdisciplinary Progress Note, dated 01/05/19, that showed the Client's toenail was coming off	W 333		

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W 333	Continued From page 72 and it was fungal and brittle. A Physician prescribed antibiotics on 01/07/19 to treat the redness and swelling of the toe. The file did not contain a Nursing Care Plan that addressed the infection or potential adverse reactions to the antibiotics. Record review of Client #8's Attendant Counselor (AC) Orders for January 2019 showed that ACs were not alerted to what they should monitor for and report to nursing in relation to the infected toe and use of antibiotics to treat the infection. Record review of the facility Nursing Process 2007 (provided by the facility) showed that after assessing the Client, the Registered Nurse (RN) should check the Clients' Nursing Care Plans and if the issue was not addressed in them, a new care plan should be initiated. The RN should also initiate nursing orders for ACs. During an interview on 01/14/19 at 9:25 AM, Staff EE, RN Manager, and Staff FF, RN Manager, stated that the RN should have initiated a Nursing Care Plan to address the Client's fungal toenail, the antibiotics, and preventive measures to address recurrence. The RN should have initiated AC nursing orders so staff could monitor for and report concerns related to the infection and the use of antibiotics.	W 333		
W 337	NURSING SERVICES CFR(s): 483.460(c)(3)(iv) Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be recorded in the client's record.	W 337		

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W 337	Continued From page 73 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a Quarterly Health Assessment was complete and in the file for one of six Sample Clients (Client #4). This failure resulted in incomplete information in the record, and prevented the facility from analyzing pain management accurately for the Client. Findings included ... Record Review of a Chronic Pain Assessment/Review - 90 Day form, dated 06/06/18, showed: 1. That although the form was dated 06/06/18 at the top, it contained information for three quarterly assessments. 2. Section 2 had the same date of 06/06/18 for each different quarterly review. The other sections showed dates for 09/02/18 and 11/25/18. 3. Section 4 contained two, instead of three, quarterly reviews with no dates to indicate which reviews they were for. 4. Section 5 did not contain the date of the last update for the Nursing Care Plan for pain. 5. Section 6 did not contain the date of the last update for the Nursing Orders for pain. During an interview on 01/10/19 at 10:01 AM, Staff E, Registered Nurse (RN), stated that the dates were missing.	W 337		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed	W 436		

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W 436	Continued From page 74 choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure one of six Sample Clients (Client #3) had training plans to use and maintain his prescription eyeglasses. This failure prevented Client #3 from benefiting from their use. This is a repeat citation from the 05/31/17 survey. Findings included ... Review of Client #3's Individual Habilitation Plan (IHP), dated 07/10/18, showed Client #3's prescription eyeglasses will be offered to him on AM shift and PM shift after lunch and dinner. Observation on 01/09/19 from 11:32 AM to 12:12 PM showed Client #3 got and ate his lunch. After lunch, Direct Care Staff (DCS) did not offer Client #3 his eye glasses. Observation on 01/09/19 from 5:18 PM to 6:00 PM showed Client # 3 got and ate his dinner. After dinner, DCS did not offer Client #3 his eye glasses.	W 436		

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W 436	Continued From page 75 During an interview on 01/09/19 at 6:30 PM, Staff L, Qualified Intellectual Disability Professional, and Staff N, Attendant Counselor Manager, stated that there was no formal teaching plan or instructions for staff on how to help Client #3 wear and maintain his prescription eyeglasses.	W 436		
{W 448}	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: This regulation was not reviewed as part of the Focused Fundamental Survey for 01/15/19. It remains out of compliance from the 05/31/17 Survey and the 06/29/18 Survey.	{W 448}		
{W 449}	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills and take corrective action. This STANDARD is not met as evidenced by: This regulation was not reviewed as part of the Focused Fundamental Survey for 01/15/19. It remains out of compliance from the 05/31/17 Survey and the 06/29/18 Survey.	{W 449}		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections.	W 454		

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W 454	Continued From page 76 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure staff followed the facility guidelines for infection control for one of six Sample Clients (Client #5). This failure resulted in an unsanitary environment due to potential exposure to blood borne pathogens, and germs from the comingling of Clients' personal belongings. Findings included ... Environment Observation at [redacted] House on 01/07/19 at 7:41 AM showed Client #5 had blood drawn from his right arm. At 7:45 AM, as Client #5 propelled his wheelchair into the dining room, the bandage on his right arm dripped blood on the floor. Staff wiped the blood from the floor with a dry towel. Record review of facility Standard Operating Procedure (SOP) titled, "4.25 Bloodborne Pathogen Exposure Control Plan," showed that environmental surfaces were to be cleaned and disinfected after contact with blood. During an interview on 01/07/19 at 10:28 AM, Staff Y, Attendant Counselor Manager, stated that staff should have used a mop and cleaner to sanitize the floor. During an interview on 01/11/19 at 9:24 AM, Staff DD, Infection Control Nurse, stated that staff should have followed the SOP to clean the floor.	W 454		

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W 454	Continued From page 77 Clothing Observation at [redacted] House on 01/07/19 at 9:23 AM showed that Staff CC, Attendant Counselor, placed a waterproof poncho on Client #5 that she obtained from another Client's room. Staff CC stated that she found it in another Client's room, under his coat. During an interview on 01/07/19 at 9:26 AM, Staff CC stated that the covering was not dirty. Observation at [redacted] House on 01/07/19 at 9:32 AM showed Staff CC removed the waterproof poncho from Client #5 and placed it in the laundry room.	W 454		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to serve the appropriate diet texture to one of six Sample Clients (Client #1). This failure placed Client #1 at risk for choking. Findings included ... Observation at [redacted] House on 01/09/19 at 11:38 AM showed tater tot casserole for lunch. At 11:56 AM, a whole tater tot fell from Client #1's spoon back on to his plate.	W 474		

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W 474	Continued From page 78 Record review of Client #1's eating protocol, dated 07/02/18, showed he was on a ground diet and his food should be cut in ¼ inch pieces. During an interview on 01/09/19 at 11:55 AM, Staff MM, Food Service Worker, stated that Direct Care Staff were responsible for altering the food to the appropriate texture.	W 474		